NATIONAL COALITION FOR HOSPICE AND PALLIATIVE CARE

COALITION MEMBERS

American Academy of Hospice and Palliative Medicine (AAHPM)

Association of Professional Chaplains (APC)

Center to Advance Palliative Care (CAPC)

HealthCare Chaplaincy Network™ (HCCN)

Hospice and Palliative Nurses Association (HPNA)

National Hospice and Palliative Care Organization (NHPCO)

National Palliative Care Research Center (NPCRC)

Physician Assistants in Hospice and Palliative Medicine (PAHPM)

Social Work Hospice & Palliative Care Network (SWHPN)

Society of Pain & Palliative Care Pharmacists (SPPCP)

**October 2019** ***Reviewed and approved by Coalition members***

## Hospice Program Integrity Initiatives

The Coalition represents the ten leading professional organizations dedicated to advancing the delivery of high-quality hospice and palliative care to all who need it. The national organizations that form the Coalition represent more than 5,300 hospice programs and their related personnel, 5,200 physicians, 1,000 physician assistants, 11,000 nurses, 5,000 chaplains, 8,000 social workers, researchers, and pharmacists, along with over 1,800 palliative care programs caring for millions of patients and families each year across the United States. As such, we bring a broad, multidisciplinary perspective on any proposed legislative or regulatory changes to the hospice program and its impacts on the vulnerable patients that our members and the program serves.

In July 2019, two OIG reports identified vulnerabilities in the Medicare hospice benefit. Among the recommendations in OIG's first report were the following: strengthen the survey process, establish additional enforcement remedies, and provide more information to beneficiaries and their caregivers.[1] The second OIG report on safeguards made several recommendations including: CMS should seek statutory authority to establish additional, intermediate remedies for poor hospice performance and strengthen requirements for hospices to report abuse, neglect and other harm.[2]

Below are recommendations from the Coalition on possible program integrity initiatives that Congress and/or CMS should implement. The Coalition welcomes the opportunity to be a partner in establishing the highest possible quality and compliance for hospices, always remaining committed to all patients, families and caregivers who are living with serious illness nearing the end of life.

[1] https://oig.hhs.gov/oei/reports/oei-02-17-00020.asp?utm_source=mmpage&utm_medium=web&utm_campaign=OEI-02-17-00020

[2] https://oig.hhs.gov/oei/reports/oei-02-17-00021.asp?utm_source=mmpage&utm_medium=web&utm_campaign=OEI-02-17-00021

info@nationalcoalitionhpc.org
www.nationalcoalitionhpc.org

**Hospice Program Integrity Initiatives-Coalition Recommendations**
***Reviewed and approved by Coalition members October, 2019***

| Category | Specific Recommendations |
|---|---|
| **Program Integrity Reforms to Establish Additional Enforcement Remedies and Establish Additional, Intermediate Remedies for Poor Hospice Performance**[3] | **1. Additional Statutory Authority for Intermediate Sanctions:** CMS should seek statutory authority to establish additional, intermediate remedies for poor hospice performance. Instead of civil monetary penalties**,** **i**nclude a directed plan of correction with oversight, put the hospice on an action plan with very specific timeframes and target dates, more frequent surveys, even as frequently as every 6 months, require progress reports and data to be submitted showing ongoing compliance with the corrective action. CMS should identify a process for hospice providers who continue to have compliance issues, condition-level deficiencies, or incidents of patient harm. |
| | **2. Increase Payment Reduction for Not Participating in Quality Reporting:** The Coalition recommends doubling the payment reduction for not reporting quality measures from 2% to at least 4%. This will be an incentive to submit hospice quality reporting program data and reduce the number of programs that do not participate in the Medicare hospice quality reporting program (HQRP).[4] |
| | **3. Transparency:** CMS should delineate and define the deficiencies and factors that identify the 313 hospices as "poor performers," share the list of poor performing hospices with Congress and members of the public. |
| | **4. Tools and Resources:** Members of the Coalition will collaborate to enhance current resources and create focused materials that will allow providers to assess and |

[3] Criminal background checks for all hospice staff and volunteers was implemented in 2008 as a part of the revised Medicare Hospice Conditions of Participation at **§ 418.114 (d)**

[4] In 2016 there were 514 hospices that did not participate in the quality reporting program 2% being $12,386,481 and 4% being $24,772,963, if you stretch the additional 2 percent payment reduction over a period of 10 years $124 million in new savings could be realized.

| Category | Specific Recommendations |
|---|---|
| | improve their standing as a provider – identifying areas where they meet the highest quality standards today, areas for performance improvement and areas that need intensive improvement. Collaboration should also continue with the accrediting organizations and the Medicare Administrative contractors to develop resources and assist in providing education and guidance. |
| **Program Integrity Reforms to Strengthen the Survey Process and Oversight** | **5. Survey Frequency:** CMS should require all new initial certification surveys and surveys for poor performing hospice providers to be completed annually -- either by the state survey agency or the accrediting organization. These two groups of hospices should submit data regularly for review. Annual surveys for poor performers should end if the plan of correction is followed and no condition-level deficiencies are detected two years in a row. |
| | **6. Education for Surveyors:** CMS should provide additional standardized, computerized program for training, education and **competency evaluations** for hospice surveyors to ensure knowledge of hospice regulations and consistency of surveys, including both state survey agencies and accrediting organizations. |
| **Program Integrity Reforms to Provide More Information to Beneficiaries and Their Caregivers** | **7. Share Comparable Survey Results:** The Coalition supports releasing comparable survey results from state agencies and accrediting organizations at some point in the future on Hospice Compare to allow consumers to make informed decisions. |
| | **8. Improve/Upgrade Hospice Compare:** The Coalition and its members will work with CMS to improve upon/upgrade the Hospice Compare system. Coalition members note that there should be a focus on improvements in accuracy and timeliness, as often the data in Hospice Compare is incomplete and many months out of date, giving the public a superficial and potentially misleading impressing of a provider. |
| **Program Integrity Reforms to Enhance Patient Access and Understanding** | **9. Access to Hospice for Patients and Beneficiaries in Underserved Areas:** Congress should remove a statutory barrier that restricts access to hospice in underserved communities including rural communities. When a Medicare beneficiary becomes eligible for hospice, they select a physician, nurse practitioner or physician assistant |

| Category | Specific Recommendations |
|---|---|
| | to serve as their attending physician. Unfortunately, providers working in Rural Health Centers (RHC) and Federal Qualified Health Centers (FQHC) cannot bill and be paid for hospice attending physician services. This statutory barrier restricts choice for some of the most underserved populations by not allowing patients to choose the RHC or FQHC provider they know and trust to serve as their attending during hospice care.[5] |
| **Program Integrity Reforms to Educate Hospices About Common Deficiencies and Those That Pose Particular Risks to Beneficiaries** | **10. Training in Abuse, Neglect and Harm:** CMS should provide educational resources to hospice staff to assist in identifying signs of abuse, neglect and other harm. |
| | **11. Remedial Education for Poor Performing Hospices:** CMS should require poor performing hospices to enroll in remedial education or continuing education from an approved hospice compliance vendor and to submit their participation to the state survey agency or accrediting organization for oversight. Providers could select a vendor of their choice but must show proof of participation. |
| | **12. Best Practices in Quality:** Coalition members will work to develop resources on Quality Assessment/Performance Improvement, monitoring and analysis of quality trends, benchmarking, HQRP basics, interpreting and improving Hospice CAHPS® scores, PEPPER report utilization, and internal reporting on quality indicators and measures. |
| | **13. Best Practices in Compliance:** Coalition members will continue to provide robust training in compliance for the hospice provider community, including compliance risk assessment, compliance policies and procedures, and anonymous reporting. |

[5] This proposal has been introduced as the Rural Access to Hospice Act H.R. 2594/S. 1190 and received technical assistance from CMS in 2018.